



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

GULF COAST MEDICAL EVALUATIONS
1805 NORTHERN DRIVE
LEAGUE CITY TX 77573

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

METROPOLITAN TRANSIT AUTHORITY HARRIS CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-3137-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary, as stated on the Table of Disputed Services: "all information needed by carrier was sent."

Amount in Dispute: \$816.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This injury has been limited by agreement to a lumbar spine sprain/strain injury. The parties specifically agreed that the compensable injury does not extend to include the cervical spine, the bilateral knees, the bilateral legs, or the bilateral shoulders."

Response Submitted by: Flahive, Ogden & Latson; PO Drawer 13367; Austin TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 22, 2010	97750-FC	\$816.00	\$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated December 14, 2010

- 218 – based on entitlement to benefits
- 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
- Comments:
 - 218 – Metropolitan Transit Authority denies that an injury was sustained in course and scope of employment on 09/11/10. Notice of injury on 09/17/10. Carrier filed PLN-1 on 10/01/10.
 - 150 – Documentation submitted does not support the level of service. Per DWC rule 134.204(G): FCEs shall also include the following elements: (1) (A) A physical examination and neurological evaluation, which include the following: (A) appearance (observation and palpation); (B) flexibility of the extremity joint or spinal region (usually observational); (C) posture and deformities; (D) vascular integrity; (E) neurological tests to detect sensory deficit; (F) myotomal strength to detect gross motor deficit; and (G) reflexes to detect neurological reflex symmetry and (3) Functional abilities test, which include the following: (C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill.

Explanation of benefits dated February 15, 2011

- 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
- 193 – Original payment decision is being maintained. This claim was processed properly the first time.
- Comments:
 - 193 – Reaudit based on BDA (benefit dispute agreement)
 - 150 – Documentation submitted does not support the level of service for a FCE. Per DWC rule 134.204(G): FCEs shall also include the following elements: (3) Functional abilities tests, which include the following: (C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill.

Issues

1. Does the dispute contain extent of injury issues?
2. Did the requestor document the following required elements of an FCE: Submaximal cardiovascular endurance tests using stationary bicycle or treadmill per 28 Texas Administrative Code §134.204(g)?
3. Is the requestor entitled to reimbursement?

Findings

1. The respondent's original explanation of benefits included denial reason "218 – based on entitlement to benefits". However, upon reconsideration, this denial reason was not maintained by the respondent due to a Benefit Dispute Agreement. A Benefit Review Conference was held on February 3, 2011 and an Agreement was reached. The Agreement states, "The parties agree the Claimant sustained a compensable injury on 09/11/10. The parties agree the compensable injury of 09/11/10 extends to include the diagnosed lumbar sprain/strain but it does not extend to include bilateral legs, bilateral knees, cervical and bilateral shoulders." Therefore, the disputed services will be reviewed in accordance with applicable Division rules and fee guidelines.
The medical bill submitted by the requestor in this dispute was reviewed. The requestor billed with diagnosis codes 724.8 (other back symptoms); 847.2 (sprain lumbar region); 724.4 (lumbosacral neuritis NOS); and 728.85 (spasm muscle). The Division concludes that the disputed treatment was for the compensable injury.
2. The respondent's original explanation of benefits included denial reason "150 – payment adjusted because the payer deems the information submitted does not support this level of service." The respondent listed the missing required elements. The reconsideration explanation of benefits included denial reason "150 - Documentation submitted does not support the level of service for a FCE. Per DWC rule 134.204(G): FCEs shall also include the following elements: (3) Functional abilities tests, which include the following: (C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill."

28 Texas Administrative Code §134.204(g) states "The following applies to Functional Capacity Evaluations (FCEs): Documentation is required. FCEs shall include the following elements:

- (1) A physical examination and neurological evaluation, which include the following:
 - (A) appearance (observational and palpation);
 - (B) flexibility of the extremity joint or spinal region (usually observational);

- (C) posture and deformities;
 - (D) vascular integrity;
 - (E) neurological tests to detect sensory deficit;
 - (F) myotomal strength to detect gross motor deficit; and
 - (G) reflexes to detect neurological reflex symmetry.
- (2) Physical capacity evaluation of the injured area, which includes the following:
- (A) range of motion (quantitative measurements using appropriate devices) of the injured joint or region; and
 - (B) strength/endurance (quantitative measures using accurate devices) with comparison to contralateral side or normative database. This testing may include isometric, isokinetic, or isoinertial devices in one or more planes.
- (3) Functional abilities tests, which include the following:
- (A) activities of daily living (standardized tests of generic functional tasks such as pushing, pulling, kneeling, squatting, carrying, and climbing);
 - (B) hand function tests that measure fine and gross motor coordination, grip strength, pinch strength, and manipulation tests using measuring devices;
 - (C) submaximal cardiovascular endurance tests which measure aerobic capacity using stationary bicycle or treadmill; and
 - (D) static positional tolerance (observational determination of tolerance for sitting or standing)."

Review of the 'Cardiovascular Tests' portion of the FCE report documents that a step test was used instead of the required stationary bicycle or treadmill; therefore, all the documentation requirements of an FCE were not met.

3. No reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that no reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services involved in this dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May , 2012 Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.